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Fourteen hysterectomies with remarks

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FOURTEEN HYSTERECTOMIES WITH REMARKS.*

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CASE I.—I am unable to give a complete previous history of this case. It was done at Watertown for Dr. James D. Spencer on May 20, 1891, immediately after I had operated for salpingitis and ovaritis in another case. The patient had just recovered from an attack of "grip" with which she had had some lung complication but she seemed to be in fair condition. A hurried examination revealed several irregular fibromata involving the uterus. The patient took the ether very badly and her pulse was very rapid but there was no hæmorrhage during the operation. The usual incision proved the diagnosis correct and an enlarged uterus with several hard nodular fibromata six or seven inches in diameter was found.

After ligating the ovarian arteries an écraseur was passed around the cervix, which was transfixed with needles, and the mass was cut away. The cervical canal was swabbed out with pure carbolic, the peritonæum was carefully sewed to the stump below the wire of the écraseur and the wound closed. The stump was trimmed down, smeared with subsulphate of iron and dressed around with iodoform gauze to keep it separate from the rest of the wound. The patient rallied only fairly well. Dr. Spencer writes me as follows: "The day following the operation she was taken with a cough and a terrible pain in the left chest with difficulty of breathing, rapid pulse and high temperature and died about thirty-six hours after the operation. I believed her death caused by some heart and lung complication due to the anæsthetic. She apparently did not die as the result of the operation itself and did not complain of anything in that region."

* Read before the New York Obstetrical Society, March 20, 1894.

Case II was kindly referred to me by Dr. Henry Griswold and was operated upon in Bellevue Hospital on July 13, 1891.

E. D., aged forty; mother died of phthisis; general history good; no children; no miscarriages; no vaginal discharge; menstruation is regular but painful.

Three years ago she noticed a small lump the size of an egg in the left side which did not cause much pain but was sore. She stayed in bed for a week and the lump apparently passed away. Six weeks ago had an attack of vomiting and diarrhœa accompanied by great distention and sharp lancinating pain diffused over whole of abdomen.

Usual small incision reveals an elastic myoma on posterior wall of the uterus about the size of a six months' pregnancy. The incision was extended and the tumor and uterus lifted up. The ovarian arteries were ligated, cut off and allowed to retract, then an écraseur was passed around the cervix and the mass cut away, leaving about an inch of the cervix. The uterine arteries were now tied off close to the cervix. Now a wedge-shaped piece was cut out of the cervix and the canal swabbed out with pure carbolic and an iodoform-gauze drain put through the canal. The cervix, after loosening the écraseur, was then sewed up with a continuous catgut suture and then a similar suture closed over it the peritonæum which had been stripped or pushed down. The pelvic cavity was irrigated with pure water at a temperature of 112°, a glass drainage tube introduced and the wound closed by silk sutures passing through all of its structures and re-enforced by a second line of fine silk sutures which accurately approximated the fasciæ of the linea alba.

There was no shock and the convalescence was normal. A small dose of opium was given the first two nights. The drainage tube was removed the second day and the bowels were moved the third. On cutting open the tumor it was found to contain a chocolate-colored fluid with masses of broken-down material projecting from the walls. The myoma had evidently undergone some sort of degeneration.

Case III.—J. H., married, aged forty-five; was operated upon on November 20, 1891 for Dr. W. F. Strait in Rock Hill, S. C. Seven months ago was curetted for severe uterine hæmorrhages by Dr. Strait which was efficacious for about three months. Then the bleeding recurred and a second curetting, without benefit, was done and the scrapings sent to a pathologist who pronounced it adeno-sarcoma. Owing to the large size of the uterus I had great difficulty in delivering it even

after I had cut through the broad ligaments. The operation was done in a miserable hut, but she made a good recovery, though she died, six or seven months after the operation, of the "grip."

By the doctors present this was thought to be the first vaginal hysterectomy done in South Carolina but I have since heard of one which was done previously.

CASE IV.—Mrs. C., aged forty, was operated upon for Dr. St. John at the Hackensack Hospital. She has had nine children. Six months ago she began to have profuse menorrhagia and four months ago irregular hæmorrhages; a discharge in the interim was added. She became very anæmic and weak. Dr. St. John diagnosed carcinoma of the cervix and I curetted on December 29, 1892, to stop hæmorrhages and render uterus and vagina aseptic. Vaginal hysterectomy was done on the date first named and the patient was discharged February 21, 1893. On February 15, 1894, she was still in good condition.

CASE V was admitted to Bellevue October 3, 1892. Mrs. K., aged twenty-five, family history negative, general history good, had four children, the last eighteen months ago.

In the middle of September, 1892, while in the water-closet, a hæmorrhage came on but patient did not pay much attention to it, as she supposed it was a miscarriage because she had had a fright. The hæmorrhage kept up and a midwife was called in and she found something that she thought was the afterbirth. But, though she pulled on it, she could not remove it and as the hæmorrhage persisted the patient was finally brought to the hospital. Though fat she is profoundly anæmic. Examination reveals the vagina filled with a cauliflower growth projecting from the posterior lip of the cervix and a pregnancy advanced to about the fourth month.

After thorough cleansing of the vagina a catheter was introduced on October 11, 1892, and the fœtus delivered October 13th without trouble. November 5, 1892, the growth with the posterior lip of cervix was removed. The mass which was about four inches in diameter was filled with cells and glands which were broken down and purulent. The patient had no pain and she refused absolutely to have the uterus removed though it was urged and she was told that she was certain to die if it was not done. So she left the hospital November 15, 1892. Hæmorrhages forced her to return January 20, 1893. On account of foul discharge I curetted and, finally, obtaining permission I removed the uterus and appendages per vaginam February 9, 1893. Though I apparently got all the cancerous tissue and

the operation was easy I was fearful of the final result owing to the evident vigorous growth of the cancer. She made a good recovery and was discharged March 7, 1893. I saw her about six months afterward and the disease had returned in the scar and was growing very rapidly, so I feel confident she is now dead.

Case VI.—Miss C., aged fifty-one, is emaciated and very anæmic. A sister died with cancer and her father died of phthisis. Menopause occurred two years ago. A year ago she began to have a yellowish discharge and occasionally lost a little blood. She has pain and a dragging sensation in the back.

Examination reveals a very foul discharge from cervix and the uterus enlarged as if pregnant in the third month, so a curetting was done January 30, 1893.

On February 13, 1893, a cœliotomy with removal of the entire uterus was done. After ligating the uterine arteries in the usual manner and cutting away the upper portion of the vagina, several small arteries had to be ligated.

An iodoform-gauze drain was put in the vagina, the upper end just entering the peritoneal cavity. The abdominal wound was closed as usual. She made a good recovery and was doing well several months after the operation, when she was last heard from.

Case VII.—Miss B., colored, aged thirty, family and general history negative, had one child about ten years ago. Last summer she noticed that her umbilicus began to project and her abdomen began to swell, then her menstruation which had always lasted seven days was increased in amount and duration, and soon she had irregular hæmorrhages.

A diagnosis of fibromata of the uterus was made and an operation similar to that in Case II was done, except that the écraseur, even for temporary use, and washing out were abandoned and silk was used to sew up the cervix and also for the peritonæum covering it. This case was complicated by salpingitis and a cyst of the left ovary, which had to be enucleated before the uterine artery could be ligated. The sac of an umbilical hernia in which the omentum was adherent was excised and the fasciæ carefully united with silk as in the remainder of the wound.

She did not have enough pain to demand a single dose of opium after the operation and was discharged March 16, 1893, in good condition.

Case VIII.—M. L., aged twenty-three, married, no children or miscarriages, general and family history negative. Menstruation has

always been irregular. Two months ago she began to menstruate then stopped for a day or two and then began again. This process kept up for a month, then she began to bleed steadily sometimes passing large clots. Examination reveals a slightly enlarged uterus but the cervix is eaten out by an ulceration which bleeds profusely at the touch and which has left a mere shell of the cervix, as it has extended up to the internal os and nearly to the vaginal wall. A curetting was done by Professor W. Gill Wylie on May 8, 1893. On May 15th I performed vaginal hysterectomy. She made a good recovery and was discharged June 13, 1893.

This patient I saw about a week ago and, though a portion of the scar is quite hard, that is the only evidence whatever of a return. I can not say that this hardness is any more marked than that left in any case.

Case IX.—M. D., aged thirty-eight, married, had one child twelve years ago. Family and general history negative. Menstruation regular and amount moderate but it is painful. She has not been well for two years. Ten months ago she discovered a tumor in the right side and since then has had constant severe pain in that region. In this case, operated on in Bellevue July 17, 1893, there was a sessile fibroma five or six inches in diameter and numerous smaller ones in the uterine wall, and on the right side they had split the broad ligament so that they had to be enucleated before the uterine artery could be ligated. This case was also complicated by double pyosalpingitis, which of course made the operation longer and more difficult, but as no pus was spilled no drainage was used and the operation was done as in Case VII.

She made a good recovery except for a pneumonia which developed about the twelfth day after the operation. She was discharged August 29, 1893.

Case X.—K. T., aged forty-six, family and general history negative, had ten children, the last nine years ago. Menstruation regular till last April when she flowed continuously for one month, then she became regular but lost much blood. Last menstruation began in the middle of July and has kept up ever since. Has had more or less bearing-down pain ever since last April.

Examination reveals symmetrically enlarged uterus and an eroded lacerated cervix, which itself looks malignant. Second day after admission she was curetted and a growth about an inch in diameter was removed from the posterior wall of the cervix. The pathologist reported it to be a mixed-cell sarcoma. Vaginal hysterectomy was done

August 17, 1893, and she made a normal recovery and was discharged September 17, 1893.

Case XI.—M. D., aged thirty-five years, had five children, the last seven months ago; family and general history negative. Last menstruation sixteen months ago. On getting up after birth of last child she began to have severe pain in the sides and back when walking around but would be relieved by lying down.

On straining at stool the uterus comes down and out and has to be pushed back before fæces can be passed. Has leucorrhœa. I proposed to curette and do an anterior and posterior colporrhaphy for the endometritis and prolapse, but on trying to dilate the atrophied cervix I did that which I have *not* done before—that is, split the cervix—though I had recognized the atrophied condition and used very little force. I found that the tear extended to the peritonæum so I proceeded to do vaginal hysterectomy. The patient made a painless and smooth recovery. On examining the uterus it was found to be very easily torn with the fingers. I sent the specimen to a laboratory for examination but it was lost.

Case XII.—Mrs. F., aged twenty-nine, colored, was operated upon in the Hackensack Hospital for Dr. Howard McFadden on November 3, 1893.

Dr. McFadden diagnosed a fibroma in the summer of 1892, but it was not till September, 1893, that pain caused her to come for relief. She had adhesions of omentum over the uterus and the case was rendered tedious and difficult owing to very dense adhesions around old contracted forms of salpingitis and ovaritis on both sides, which obscured anatomical relations. The fibroid mass was about seven or eight inches in diameter. Operation similar to Case VII. Had an easy recovery.

Case XIII.—E. M., aged thirty-five, married one year ago, was brought to me by Dr. Mills of Middletown, N. Y.

Menstruation was regular up to June 30, 1893, since which period she has not menstruated. Two years ago she thinks she injured herself lifting, after which she had severe pain low down in front and in the left iliac region which lasted for two days. Then she first noticed a lump the size of a walnut in the left iliac region which was hard and tender on pressure. This mass has continued to grow slowly up to four months ago, when it lost its mobility and increased quite rapidly up to the present. Three weeks ago she had an attack accompanied by fever and severe pain in the hypogastric region, which was thought to be a local peritonitis. The pain has kept up ever since, but is

felt most in the vulva now. Since July morning nausea and vomiting have existed. After a physical examination I confirmed Dr. Mills's diagnosis of pregnancy complicated by fibromata, though he thought one of the tumors might be a cyst, owing to its very rapid growth. The abdomen was irregularly shaped and about the size of a full-term pregnancy. A fibroid mass filled the right side of the true pelvis, starting well in front between the cervix and the pubis, and passed around backward and upward. This mass was fixed firmly. The left side of the true pelvis was free. Above and to the right of the uterus proper was another large mass. On November 6, 1893, I operated at Bellevue. A small opening was made and the diagnosis confirmed; then, owing to the size of the mass, the belly was laid open from the pubis to within several inches above the umbilicus. A small quantity of bloody fluid was found free in abdominal cavity as soon as the peritonæum was opened. After ligating the ovarian arteries the mass could be partially lifted up, but the peritonæum had to be cut and the tumor in the right broad ligament enucleated before I could get at the right uterine artery.

This was done with great care, owing to the size of the blood vessels, but was not as difficult as I had anticipated.

The cervix was then cut off and treated as in Case VII. On cutting open the uterus the membranes were found intact and the fœtus still alive.

The uterus was found to be the seat of several interstitial fibroids divided into two great masses, the one partially surrounding the cervix anteriorly at the right and the other projecting upward to the left. Recovery was normal; no opiates needed. She went home December 6, 1893.

Case XIV.—M. R., aged twenty-one, has always been healthy, except for diphtheria in childhood, but uses stimulants excessively. One sister was weak-minded and had convulsions. She had one child ten months ago without trouble and an abortion at the third month two weeks ago, which was produced by pills. She thinks only a part came away. One week after the abortion she began to flow violently and it continued for a week, during which time she had cramp-like pains in hypogastrium and back.

On admission to Bellevue Hospital she had a temperature of 102° and pulse of 116.

On January 29th under ether I found the uterus much enlarged but no noticeable enlargement of the appendages. I dilated the cervix and removed with the forceps and curette much shreddy material.

She had no bad symptoms and was discharged in good condition on February 17, 1894. March 3d she was readmitted. For the past ten days she has had a leucorrhœa and a severe pain at times in the right iliac region. This pain has been constant for twenty-four hours. She has some vomiting and her temperature is 100°. A considerable mass can be felt on the right but nothing definite on the left of the uterus. March 5, 1894, I performed cœliotomy and found a double salpingitis with an abscess containing greenish pus in each uterine end of the tubes about an inch in diameter, so that to remove the abscesses I should have had to exsect a portion of each cornua; hence I proceeded to remove the entire uterus putting an iodoform-gauze drain in the vagina. Though she lost but little blood she had a rapid pulse after the operation and her temperature rose to 102° that night and, though the temperature and pulse gradually subsided, they did not reach the normal point. The bowels were moved on the second day. The urine was sufficient in quantity but contained a little albumin and granular casts. One week after the operation at 9 A. M. she awoke, cried out with a hunger pain in pit of stomach and had a convulsion, in which she was deeply cyanosed, and which the nurse thought lasted fifteen minutes; then another of shorter duration came on almost immediately.

At 9.15 A. M. a hypodermic of a sixth of a grain of morphine and a thirtieth of strychnine were given. She had convulsions of several minutes' duration up to 2 P. M., having ten in all. At 12.30 P. M. a hypodermic of a hundredth of a grain of hyoscine was given and at 2.30 P. M. sixty grains of bromide of soda were given by rectum and a quarter of a grain of morphine hypodermically. During the convulsions she bit her lip, passed her urine involuntarily and the pulse rose to 144.

After the convulsions she was very restless and talked irrationally but would not answer questions. No special change occurred in pupils. Hypodermics of morphine and hyoscine were kept up at five-hour intervals until next morning but were alternated with digitalis. On becoming conscious she complained of hunger. She became gradually better and by March 15th was doing well and has so continued since.

Thus I have done fourteen hysterectomies. Eight were suprapubic and in six of these, which were done for fibroma without disease of the cervix, I left a small portion of the cervix; in the remaining two I removed the uterus completely, one being for sarcoma and

one for suppurative inflammation of tubes involving the cornua of the uterus. Of the remaining six I did vaginal hysterectomy in two for sarcoma, in three for carcinoma and in one for accidental splitting of the cervix and prolapse of the uterus. Now, as to the first case and my only death I do not blame the method though I believe it to be obsolete now, as it is difficult to imagine a case that would require it considering the results of intra-abdominal methods. However when it is done properly—that is, the ovarian arteries tied and allowed to drop back so as to take off tension in the broad ligaments and then the peritonæum properly approximated to the stump below the wire of the écraseur—the operation is still a safe one as far as saving life is concerned. Many of the cases lost by this method were lost owing to the leaving of a portion of the stump, that must die within the peritoneal cavity, or to the slipping of such a portion back before protective adhesions had taken place. This case of mine certainly died when she did because I operated upon her, but that it was the fault of the operation is not at all certain. It seems I was not careful in operating on a woman suffering from the sequelæ of "grip."

It is noticeable that this was the only case of fibromata uncomplicated by local disease or change. One had undergone cystic degeneration, two had also salpingitis and ovaritis, one had pyosalpingitis and one was complicated by pregnancy. I have observed that in nearly all the cases of fibromata that I have seen operated upon, in which pain was one of the indications for operation, salpingitis was present or the tumors themselves had undergone degeneration. It is singular that of the six cases done for malignant disease three were for sarcoma of the fundus, and in two for carcinoma one was only twenty-three and the other twenty-five years of age. Of course we see a large number of inoperable cases of cancer of the cervix, as far as complete removal is concerned, and surely malignant disease begins there much oftener, but undoubtedly a certain number of cases where the fundus is first attacked are overlooked because the diagnosis is more difficult, first and last.

In Case XI I am bound to say the hysterectomy was done largely on account of the accident, as I believe we ought to remove the uterus for prolapse in rare instances. I would not ordinarily do hysterectomy for prolapse, unless there should be no possibility of childbirth due to some growth or disease of the appendages or to the age of the patient, because less dangerous and less radical measures are nearly always successful and, where they are not, taking out the uterus is no guarantee of permanent success. The mere weight of the uterus has

frequently nothing to do with the extreme forms of prolapse, as in the worst cases of prolapse in old women the organ is frequently so atrophied that it need not be considered ; in fact prolapse of the uterus is a misnomer in such cases, as the condition is more properly one of hernia. Time is the great test for operations for radical cure of hernia and the substitution of a stretched ulcerating scar would be a poor exchange, even for an ulcerated cervix and vagina which we see in these old cases of inversion of the vagina. In doing vaginal hysterectomy we ordinarily tie the ends of the round ligaments into the stump and I believe this ought to be done in all abdominal hysterectomies also, as it would tend to prevent hernia or prolapse.

It may be that as time goes on, especially as hysterectomies are so fashionable, we will have a harvest of hernias through the pelvic floor. I wish to draw attention to the fact that there was bloody fluid free in the abdominal cavity in the case of fibromata complicated by pregnancy, and that the fœtus was living in the uterus several minutes after the organ had been amputated. Where the child is viable, it would be simpler than the ordinary operation if you could take away the uterus with its contents intact without danger to the child. In doing the vaginal hysterectomies, a point which I learned from Professor W. Gill Wylie has saved time and simplified the operation, namely, that it is useless to dissect around the cervix, pushing up the tissues as you pull it down and perhaps tying several times to stop bleeding, as it is frequently easy to grasp the vaginal wall contiguous to Douglas's pouch with bullet forceps and then cut with a scissors directly into the peritonæum. By enlarging this opening you can palpate the uterine artery and tie it without fail.

Though the mortality from vaginal hysterectomies is very small, complete removal by cœliotomy is, I believe, the operation of the future, as more of the diseased tissue in broad ligaments and vagina can be removed than by vaginal hysterectomy. A word about hysterectomy for diseases of the appendages and I am done. I expect to do complete hysterectomy for suppurative disease of the appendages in certain cases, as in my last case, where the uterus is much diseased or is a source of active sepsis or where free drainage is required. But I believe the field should be only gradually extended until we know more about the effect of coition with only a scar at the upper end of the vagina and whether we are going to have hernias through the vagina.

Undoubtedly nearly all the disagreeable after-symptoms in removal of the appendages can be avoided by ligating separately the

ovarian arteries, dividing the broad ligaments and allowing the arteries to retract, as in hysterectomy, then ligating close to the uterus including the round ligament. By this method you can cut away *all* diseased tube and ovary and definitely stop menstruation, and the uterus is kept in the anterior position certainly. Of course curetting should be added or done previously.

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